STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #40890, #41025, #41212, and #41269 were completed on 5/10/17 at Claiborne and Hughes Health Center. No deficiencies were cited related to complaint investigation #40890. Deficiencies were cited related to complaint investigation #41025, #41212, and #41269 under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to notify the physician the ordered urine analysis (U/A) and culture was not obtained for 1 resident (#1) of 8 residents reviewed. The findings included: Review of facility policy, Policy for MD/RP (Medical Doctor/Responsible Party) Notifications, undated revealed "...PURPOSE: To keep the physician, who is in charge of the medical care...informed of the resident's medical condition...STANDARD: Notification of the physician...should occur promptly, according to federal regulations, when there is a change in the resident's condition..."	F 157		

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F 157	Continued From page 2 Medical record review revealed Resident #1 was admitted to the facility on 2/4/15 with diagnoses including Left at Knee Amputation, Diabetes Mellitus Type 2, Peripheral Vascular Disease, Pain, Depressive Disorder, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Congestive Heart Failure, L-3 Compression Fracture, and Right Femoral Neck Fracture. Medical record review of the Telephone Physician Order dated 3/23/17 revealed "...U/A + [and] culture..." Medical record review of the Lab Log, with Licensed Practical Nurses (LPN's) #2 and #3 present, revealed the 3/23/17 U/A order was documented in the Lab Log to be obtained on 3/24/17. Further review revealed a written notation "...Unable to Obtain..." Interview with LPN's #2 and #3 on 5/9/17 at 3:00 PM at the 1 East nursing station confirmed the 3/23/17 U/A and culture order had been documented in the Lab Log and the facility was not able to obtain a specimen. When the LPN's were asked if the physician had been notified the U/A had not been obtained, the LPN's confirmed the facility failed to notify the physician until 5/8/17. Interview with the Administrator and the Director of Nursing on 5/9/17 at 4:25 PM in the Administrator's office confirmed the facility failed to notify the physician the U/A had not been obtained and seek further instructions.	F 157		
F 225 SS=E	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 3 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		

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F 225	Continued From page 4 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to report an allegation of abuse for 1 resident (#1), failed to report 2 allegations of abuse timely for 2 residents (#3, #4), and failed to thoroughly investigate allegations of abuse for 3 residents (#1, #3, #4) of 5 residents reviewed for abuse. The findings included: Review of facility policy, Abuse Prevention and Intervention Strategies, dated 11/16 revealed "...It is the policy of this facility to protect its residents	F 225		

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F 225	Continued From page 5 from abuse...has implemented a program of abuse prevention and intervention strategies...Investigation: The facility will investigate all injuries of unknown origin and all allegations of mistreatment, neglect or abuse. All investigations will be conducted in a timely, thorough and objective manner...Any incidents of substantiated abuse and neglect are reported and analyzed and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State or Federal law..." Medical record review revealed Resident #1 was admitted to the facility on 2/4/15 with diagnoses including Left Knee Amputation, Diabetes Mellitus Type 2, Peripheral Vascular Disease, Pain, Depressive Disorder, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Congestive Heart Failure, L-3 Compression Fracture, and Right Femoral Neck Fracture. Review of the facility investigation dated 3/24/17 revealed the Director of Nursing (DON) had interviewed Resident #1 regarding statements of "...[Licensed Practical Nurse (LPN) #3]...repositioning in bed...slammed her head..." Further review of the facility investigation revealed 2 written statements, one was dated 3/31/17 signed by LPN #3 and the second was dated 4/5/17 signed by LPN #5. Interview with LPN #3 on 5/8/17 at 11:10 AM in the Social Worker's office revealed the LPN was aware of the allegations and wrote a statement of not transferring or repositioning Resident #1 on 3/24/17. Interview with the DON on 5/8/17 at 4:30 PM in the conference room revealed LPN #5 had	F 225		

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F 225	Continued From page 6 informed the DON of the incident on 3/24/17. Interview with LPN #5 on 5/9/17 at 4:25 PM at the 1 East nursing station revealed he had been in Resident #1's room providing care and the resident repeatedly stated LPN #3 had "...slammed me in the bed..." and "...grabbed me for no reason..." Further interview revealed LPN #5 informed the DON the day of the incident. Further interview revealed LPN #5 checked the resident for any marks and found none. Further interview confirmed LPN #5 failed to document the resident's physical condition and the alleged incident on 3/24/17. Interview with the Administrator and the DON on 5/10/17 at 4:00 PM in the conference room confirmed the incident of alleged abuse occurred on 3/24/17. Further interview confirmed the facility failed to report the allegation of abuse to the State Agency. When the Administrator and DON were asked if other staff and residents were interviewed, were non-interviewable residents checked for safety, did the facility get statements on the day of the event, was Resident #1 physically and mentally checked out, did the facility complete a thorough investigation of the allegation, the Administrator stated "...We steered in the wrong direction..." Further interview confirmed the facility failed to complete a thorough investigation of the abuse allegation. Medical record review revealed Resident #3 was admitted to the facility on 11/23/16 with diagnoses including Vascular Dementia without Behavioral Disturbance, Hypertension, Idiopathic Gout, Gastro-Esophageal Reflux Disease with Esophagitis, Chronic Atrial Fibrillation, Pain, and Long term (current) use of anticoagulants.	F 225		

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F 225	Continued From page 7 Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/22/17 revealed Resident #3 had a Brief Interview of Mental Status (BIMS) of 10 indicating the resident was moderately cognitively impaired. Medical record review revealed Resident #5 was admitted to the facility on 10/5/16 with diagnoses including Unspecified Dementia with Behavioral Disturbance, Type 2 Diabetes Mellitus, Hypertension, Anxiety Disorder, and Restlessness and Agitation. Medical record review of the Quarterly MDS dated 1/17/17 revealed the BIMS could not be conducted because the resident was rarely/never understood. Further review revealed the resident had trouble concentrating nearly every day and had no behavioral symptoms. Further review revealed the the resident had short and long term memory problems and the cognitive skills for daily decision making were severely impaired. Review of the facility investigation included an Occurence Report signed by the DON on 4/11/17 and revealed Resident #3 was slapped by Resident #5 on 4/8/17. Continued review revealed the investigation included a statement from Licensed Practical Nurse (LPN) #1 recounting the event, and skin assessments for Residents #3 and #5 on 4/11/17. Interview with the Administrator and the DON on 5/10/17 at 4:15 PM in the conference room confirmed the facility failed to report the allegation of abuse from 4/8/17 to the State Agency for Resident #3 until 4/14/17 and therefore was not reported in the required time frame. Continued	F 225		

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F 225	Continued From page 8 interview with the Administrator and DON revealed the facility failed to conduct additional interviews with staff and interviewable residents, and failed to check non-interviewable residents for safety on the day of the incident. Further interview with the Administrator confirmed the facility failed to thoroughly investigate the allegation for Resident #3. Medical record review revealed Resident #4 was admitted to the facility on 1/25/17 with diagnoses including Heart failure, Hypertension, Unspecified Visual Loss of Both Eyes, Cirrhosis of Liver, and Muscle Weakness. Medical record review of the Quarterly MDS dated 2/1/17 revealed Resident #4 had a BIMS of 7 indicating the resident was severely cognitively impaired. Review of the facility investigation included an Occurrence Report for Resident #4 and Resident #5. Further review revealed Resident #4 was hit by Resident #5 on 4/14/17. Continued review revealed the investigation included a statement recounting the incident, a skin assessment on Resident #4 dated 4/14/17, and the record of ongoing 15 minute checks of Resident #5 dated 4/11/17 to 4/14/17. Interview with the Administrator and DON on 5/10/17 at 4:20 PM in the conference room confirmed the facility failed to report the allegation of abuse from 4/14/17 to the State Agency until 4/21/17 and therefore was not reported in the required time frame. Continued interview with the Administrator and DON revealed the facility failed to conduct additional interviews with staff and interviewable residents and failed to check	F 225		

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F 225	Continued From page 9 non-interviewable residents for safety on the day of the incident. Further interview with the Administrator confirmed the facility failed to thoroughly investigate the allegation of abuse for Resident #4.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 226		

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F 226	Continued From page 10 (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to report an allegation of abuse timely to the supervisor/administrator/abuse coordinator for 1 resident (#3) of 5 residents reviewed for abuse. The findings included: Review of facility policy, Abuse Prevention and Intervention Strategies, dated 11/16 revealed "...It is the policy of this facility to protect its residents from abuse...has implemented a program of abuse prevention and intervention strategies...All investigations will be conducted in a timely, thorough and objective manner..." Medical record review revealed Resident #3 was admitted to the facility on 11/23/16 with diagnoses including Vascular Dementia without Behavioral Disturbance, Hypertension, Idiopathic Gout, Gastro-Esophageal Reflux Disease,Chronic Atrial Fibrillation, Pain, and Long term (current) use of anticoagulants. Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/22/17 revealed Resident #3 had a Brief Interview of Mental Status (BIMS) of 10 indicating the resident was moderately cognitively impaired. Medical record review of the Initial Wound & Skin Record for Resident #3 dated 4/11/17 revealed "...No bruises, marks or injuries noted on skin..."	F 226		

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F 226	Continued From page 11 Medical record review of a nurse's note dated 4/13/17 at 6:42 PM and written by the Director Of Nursing (DON) revealed "...Late entry for 4/11/17. Resident was sitting in her room on 4/8/17 when another resident entered her room. Resident attempted to get him out of room and when she approached the resident, he slapped her in her face..." Medical record review revealed Resident #5 was admitted to the facility on 10/5/16 with diagnoses including Unspecified Dementia with Behavioral Disturbance, Type 2 Diabetes Mellitus, Hypertension, Anxiety Disorder, and Restlessness and Agitation. Medical record review of the Quarterly MDS dated 1/17/17 revealed the BIMS could not be conducted because the resident was rarely/never understood. Further review revealed the resident had trouble concentrating nearly every day and had no behavioral symptoms. Further review revealed the resident had short and long term memory problems and the cognitive skills for daily decision making were severely impaired. Review of the facility investigation revealed on 4/8/17 Resident #5 went into Resident #3's room and slapped Resident #3 on the face. Continued review of the facility investigation revealed an undated statement written by LPN #1 recounting the events of the incident on 4/8/17. Further review of the investigation revealed the occurrence report was not written until 4/11/17 by the DON. Interview with the Administrator and the DON on 5/10/17 at 3:55 PM in the conference room revealed they were not made aware of the	F 226		

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F 226	Continued From page 12 incident involving Resident #5 hitting Resident #3 until 4/11/17. Further interview revealed it was the expectation of the administrator, who was also the abuse coordinator, for all allegations of abuse to be reported immediately to the supervisor and/or abuse coordinator. Continued interview revealed the Administrator confirmed LPN #1 failed to report the incident immediately to the supervisor and/or abuse coordinator.	F 226		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 279		

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F 279	Continued From page 13 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on facility policy, medical record review, and interview, the facility failed to develop a comprehensive care plan for 1 resident (#4) of 8 residents reviewed. The findings included:	F 279		

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F 279	Continued From page 14 Review of facility policy, Care Plans-Comprehensive, revised 10/2010 revealed "...An individualized comprehensive care plan that included measureable objectives...to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.." Medical record review revealed Resident #4 was admitted to the facility on 1/25/17 with diagnoses including Hypertension, Heart Failure, Unstable Angina, Unqualified Visual Loss of Both Eyes, Cirrhosis of Liver, and Muscle Weakness. Medical record review of a Care Plan dated 2/13/17 revealed "...BEHAVIORS: [Resident #4] displays disruptive behaviors with yelling out at times..." Further review revealed there was no goal for the care plan. Interview with the Minimum Data Set (MDS) Coordinator on 5/9/17 at 2:13 PM in her office revealed she did not list a goal for the Behavior Care Plan for Resident #4 because she was unsure at the time of the reason for the yelling and stated she was "unsure if it was psych (psychiatric) or pain or something else." Interview with the Director of Nursing on 5/10/17 at 11:00 AM in the MDS office, with the MDS Coordinator present revealed there should have been a goal even if the reason for the behaviors was uncertain. Further interview with the DON confirmed it "was inappropriate" and the facility had failed to develop a comprehensive care plan for Resident #4.	F 279		
F 280	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 280		

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F 280 SS=D	Continued From page 15 PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and	F 280		

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F 280	Continued From page 16 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280		

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F 280	Continued From page 17 assessments. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to complete a care plan within 7 days after the completion of the comprehensive assessment and failed to revise a care plan for behaviors involving hallucinations for 1 resident (#1) of 8 residents reviewed. The findings included: Review of facility policy, Care Plans-Comprehensive, revised 10/2010 revealed "...Our facility's Care Planning/Interdisciplinary Team...develops and maintains a comprehensive care plan...The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS [Minimum Data Set]...Assessments of the residents are ongoing and care plans are revised as information about the resident and the resident's condition change...The Care Planning/Interdisciplinary Team is responsible for the review and updating of the care plans..." Medical record review revealed Resident #1 was admitted to the facility on 2/4/15 with diagnoses including Left Knee Amputation, Diabetes Mellitus Type 2, Peripheral Vascular Disease, Pain, Depressive Disorder, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Congestive Heart Failure, L-3 Compression Fracture, and Right Femoral Neck Fracture. Medical record review of the Annual MDS dated 2/8/17 revealed Resident #1's Brief Interview for Mental Status was 12/15 indicating she was	F 280		

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F 280	Continued From page 18	F 280		

moderately cognitively impaired; had no mood, psychotic episodes or behaviors; she could hear adequately, and she could make herself understood and understood others.

Medical record review revealed the care plan following the comprehensive MDS was dated 3/3/17, exceeding the 7 days after the assessment.

Medical record review of the nursing notes revealed on 3/9/17 Resident #1 had experienced "...hallucinations..." Further review of nursing notes revealed the resident was seeing 1 or more children in her room or in her bed.

Medical record review of the Social Service progress note dated 3/31/17 revealed "...Res [Resident] continues to verbalize hallucinations according to nursing staff..."

Interview with the MDS Coordinator on 5/8/17 at 4:15 PM in the conference room confirmed Resident #1 had been experiencing visual hallucinations since 3/9/17 and the facility failed to revise the care plan until 4/3/17.

Interview with the MDS Coordinator on 5/9/17 at 3:15 PM in the MDS office confirmed the MDS was completed on 2/8/17 and the facility failed to complete the care plan within 7 days of the MDS.

Interview with the Administrator and the Director of Nursing on 5/9/17 at 4:05 PM in the Administrator's office, confirmed the facility failed to complete a care plan timely after a comprehensive assessment per facility policy. Further interview confirmed the facility failed to revise the care plan timely to address the

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F 280	Continued From page 19 hallucination per facility policy.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to obtain a physician order for a skin treatment for 1 resident (#6) of 3 residents reviewed receiving treatments. The findings included: Review of facility policy, Medication and Treatment Orders, revised 2/2014 revealed "...Orders for medications and treatments will be consistent with principles of safe and effective order writing...shall be administered only upon the written order..." Medical record review revealed Resident #6 was admitted to the facility on 1/26/17 with diagnoses including Fracture of Right Tibia, Pain, Dementia without Behavioral Disturbances, Diabetes Mellitus, Cerebral Infarction, and Atrial Fibrillation. Medical record review of the Telephone Physician Order dated 3/13/17 revealed "...DC (discontinue) zinc oxide cream [ointment for skin treatment] to buttock and groin q [every] shift and as needed..." Further review revealed no physician signed	F 281		

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F 281	Continued From page 20 telephone order or physician signed computerized order to initiate the the zinc oxide treatment. Medical record review of the 2/2017 and 3/2017 Treatment Administration Records revealed the zinc oxide treatment was administered from 2/15/17 to 3/13/17. Interview with Licensed Practical Nurse (LPN) #2 on 5/10/17 at 9:30 AM at 1 East nursing station confirmed she had written the 3/13/17 discontinuation of zinc oxide order. LPN #2 reviewed the telephone and computerized physician orders and confirmed the facility failed to obtain a signed physician order to initiate the zinc oxide treatment on 2/15/17. Interview with the Administrator on 5/10/17 at 10:45 AM in the conference room confirmed the facility failed to follow the facility policy to only administer medications and treatments after a physician order was obtained.	F 281		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323		

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F 323	Continued From page 21 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on facility policy, medical record review, facility investigation review, and interview the facility failed to prevent an altercation for 2 residents (#3, #4) of 5 residents reviewed. The findings included: Review of facility policy, Abuse Prevention and Intervention Strategies, dated 11/16 revealed "...It is the policy of this facility to protect its residents from abuse...has implemented a program of abuse prevention and intervention strategies...Investigation: The facility will investigate all injuries of unknown origin and all allegations of mistreatment, neglect or abuse. All investigations will be conducted in a timely, thorough and objective manner...Any incidents of substantiated abuse and neglect are reported and analyzed and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State or Federal law..." Medical record review revealed Resident #3 was admitted to the facility on 11/23/16 with diagnoses including Vascular Dementia without Behavioral	F 323		

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F 323	Continued From page 22 Disturbance, Hypertension, Idiopathic Gout, Gastro-Esophageal Reflux Disease with Esophagitis, Chronic Atrial Fibrillation, Pain, and Long term (current) use of anticoagulants. Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/22/17 revealed Resident #3 had a Brief Interview of Mental Status (BIMS) of 10 indicating the resident was moderately cognitively impaired. Medical record review revealed Resident #5 was admitted to the facility on 10/5/16 with diagnoses including Unspecified Dementia with Behavioral Disturbance, Type 2 Diabetes Mellitus, Hypertension, Anxiety Disorder, and Restlessness and Agitation. Medical record review of the Quarterly MDS dated 1/17/17 revealed the BIMS could not be conducted because the resident was rarely/never understood. Further review revealed the resident had trouble concentrating nearly every day and had no behavioral symptoms. Further review revealed the resident had short and long term memory problems and the cognitive skills for daily decision making were severely impaired. Review of the facility investigation included an Occurence Report signed by the DON on 4/11/17 and revealed Resident #3 was slapped by Resident #5 on 4/8/17. Continued review revealed the investigation included a statement from Licensed Practical Nurse (LPN) #1 recounting the event, and skin assessments for Residents #3 and #5 on 4/11/17. Interview with the Administrator and the DON on 5/10/17 at 4:15 PM in the conference room	F 323		

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F 323	Continued From page 23 confirmed the facility failed to prevent an altercation between the two residents. Medical record review revealed Resident #4 was admitted to the facility on 1/25/17 with diagnoses including Heart failure, Hypertension, Unspecified Visual Loss of Both Eyes, Cirrhosis of Liver, and Muscle Weakness. Medical record review of the Quarterly MDS dated 2/1/17 revealed Resident #4 had a BIMS of 7 indicating the resident was severely cognitively impaired. Review of the facility investigation included an Occurrence Report for Resident #4 and Resident #5. Further review revealed Resident #4 was hit by Resident #5 on 4/14/17. Continued review revealed the investigation included a statement recounting the incident, a skin assessment on Resident #4 dated 4/14/17, and the record of ongoing 15 minute checks of Resident #5 dated 4/11/17 to 4/14/17. Interview with the Administrator and DON on 5/10/17 at 4:20 PM in the conference room confirmed the facility failed to prevent an altercation between the two residents.	F 323		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 356		

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F 356	Continued From page 24 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as	F 356		

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F 356	Continued From page 25 required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the nurse staffing information for 3 of 6 days. The findings included: Observation on 5/8/17 at 8:25 AM revealed the nurse staffing information form posted by the main entrance lobby area was dated 5/4/17, Thursday. Interview with the Main Entrance Receptionist on 5/8/17 at 8:45 AM by the posted nurse staffing information form in the main entrance lobby area confirmed the form was dated 5/4/17. Further interview revealed the Receptionist posted the nursing staff information form Monday through Friday. Further interview revealed the Receptionist did not receive the nurse staffing information forms in order to post them on Friday. Interview with the Staff Development Director (SDD) on 5/9/17 at 10:45 AM by the posted nurse staffing information in the main entrance area confirmed the SDD was responsible to fill out the nurse staffing information forms. Further interview revealed the SDD was to give the nurse staffing information forms to the receptionist on Thursday to post for Friday, Saturday and Sunday. Further interview confirmed the SDD failed to provide the staffing information forms to the receptionist for 5/5/17, 5/6/17, and 5/7/17 and the information was not posted.	F 356		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET	F 520		

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F 520	Continued From page 26 QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	F 520		

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F 520	Continued From page 27 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility investigation review, and interview, the facility Quality Assurance Committee failed to identify an allegation of abuse for Resident #1; failed to report allegations of abuse to the Abuse Coordinator/Administrator timely for Resident #3; failed to report allegations of abuse to the State Agency for Resident #1; failed to report allegations of abuse to the State Agency timely for Resident #3 and #4; failed to thoroughly investigate allegations of abuse for Resident #1, #3, and #4; and for failure to ensure ongoing complaince of the Plan of Correction dated 12/30/16 for F225 and F226 was maintained and monitored by the Quality Assurance Performance Improvement (QAPI) Committee. The findings included: Interview with the Administrator and the Director of Nursing (DON) on 5/10/17 beginning at 3:55 PM in the conference room revealed the April 2017 QAPI Committee reviewed the March 2017 concerns which included 1 allegation of abuse. Further interview confirmed the facility failed to identify the 3/24/17 incident involving Resident #1 as an allegation of abuse, failed to thoroughly investigate the allegation, and failed to report the allegation to the State Agency. Continued interview confirmed the facility failed to report the allegation of abuse on 4/8/17 to the facility administration involving Residents #3 and #5 until 4/11/17, failed to report the incident to the State Agency until 4/14/17, and failed to thoroughly investigate the allegation. Further interview	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 28 confirmed the facility failed to report an allegation of abuse on 4/14/17 to the State Agency until 4/21/17 involving Residents #4 and #5, and failed to thoroughly investigate the allegation. Further interview confirmed the facility failed to ensure ongoing compliance of the Plan of Correction dated 12/30/16 for F225 and F226 was maintained and monitored by the Quality Assurance Performance Improvement Committee. Refer to F225, F226.	F 520		